
INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
To compassionately serve Hoosiers of all ages and connect them with social services, health care and their communities
WWW.FSSA.IN.GOV

Division of Family Resources

Mission - To compassionately provide all Hoosiers accurate, timely and consistent services with dignity.

Vision – To concentrate our efforts and resources on meeting Hoosiers needs today so they may focus on a creating a better tomorrow.

DFR VALUES

V **VISIBILITY** Hoosiers know who we are, what we do and how to find us.

I **INITIATIVE** Continuously inspire creative solutions by utilizing data to take action and deliver results that make a difference.

T **TEAMWORK** Working together, without borders or boundaries, to collaborate and celebrate with individuals, communities and partners.

A **ACCOUNTABLE** Take ownership of our work every day while adhering to the highest standards.

L **LEADERSHIP** Inspire growth and innovate through learning and action.

Division of Family Resources

The Division of Family Resources (DFR) determines eligibility for:

- Supplemental Nutrition Assistance Program (SNAP)
- Health Coverage
- Temporary Assistance for Needy Families (TANF)

Eligibility is determined utilizing the policies and procedures established by:

- Centers for Medicare and Medicaid Service (CMS)
- Food and Nutrition Service (FNS)
- Administration for Children and Families (AFC)

Division of Family Resources

Health Coverage Overview

- The Office of Medicaid Policy and Planning (OMPP) administers the Medicaid programs for the State, which include traditional Medicaid (fee for service) and health insurance programs to low income individuals

- DFR determines eligibility for the medical coverage programs in alignment with the policies and procedures established by Centers for Medicare and Medicaid Services (CMS)

Main categories of health coverage

- Hoosier HealthWise
- Healthy Indiana Plan (HIP)
- Medicaid for Aged, Blind, and Disabled

Anthem*, Managed Health Services (MHS)*, Medwise (MDwise) or CareSource

***Hoosier Care Connect MCE providers**

Please refer https://www.in.gov/medicaid/members/26.htm for additional information on Hoosier Care Connect

https://fssabenefits.in.gov/#/

LOGIN/REGISTER | CONTACT US | NAVIGATOR

Ready to Apply, Check Eligibility for Benefits or Check Case Information?

Ready to Apply?

Apply online for SNAP (Food Assistance), Cash Assistance, and/or Health Coverage. To print an application or have one mailed to you, click on the appropriate link below

- Apply Online for SNAP or Cash Assistance
- Apply Online for Health Coverage
- Mail me an Application
- Print an Application

Am I Eligible to Receive Benefits?

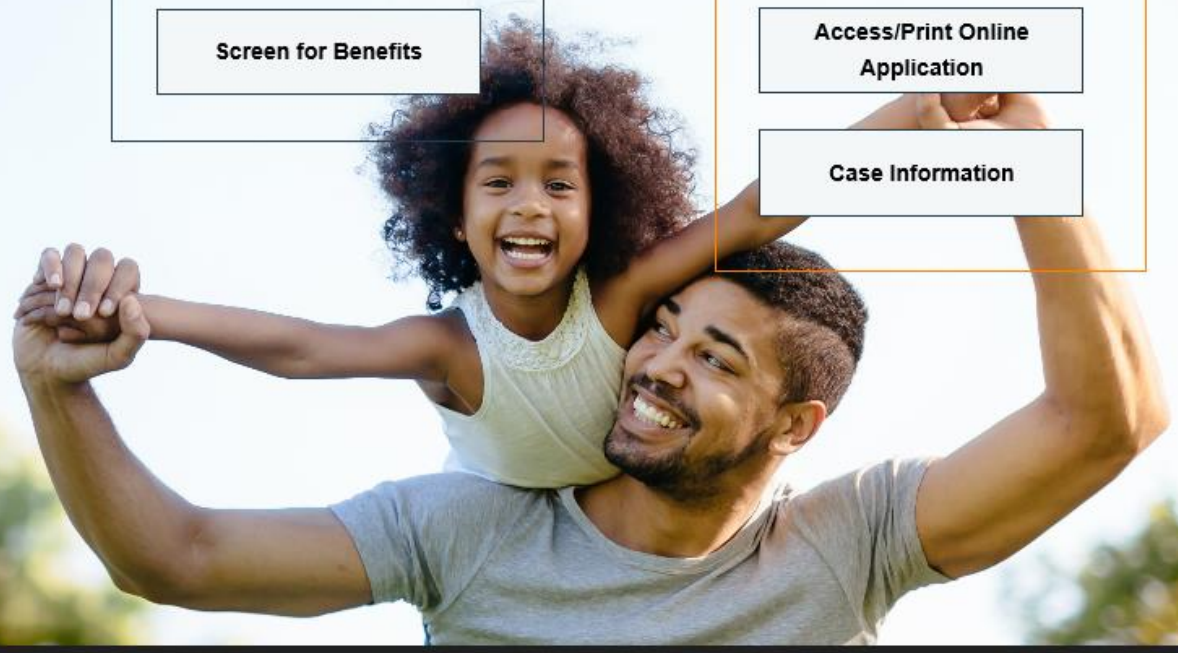
Answer the questions in the screening tool to see if you might be eligible for SNAP (Food Assistance), Cash Assistance, and/or Health Coverage benefits

- Screen for Benefits

Case Information

Check the status of an online application you submitted, review benefits you are receiving, print proof of eligibility, print an authorized representative form or Report Changes

- Access/Print Online Application
- Case Information



Submitting an Application

Type	Online	Phone	English	Spanish	Burmese
HEALTH COVERAGE	45 min	45 – 60 min	YES	PAPER ONLY	PAPER ONLY

Assistance Type	From Submission of Valid Application to Approval/Denial
Health Coverage	45 Days
Medicaid Disability	90 Days

Applications may be submitted on 24 hours a day (unless under scheduled maintenance), or in person at any local office through a self-service kiosk. Each local office has staff available to assist with application processing and questions.

Send paper applications to:

FSSA Document Center
P.O. Box 1810
Marion, In 46952
Fax 1-800-403-0864

Valid Application:

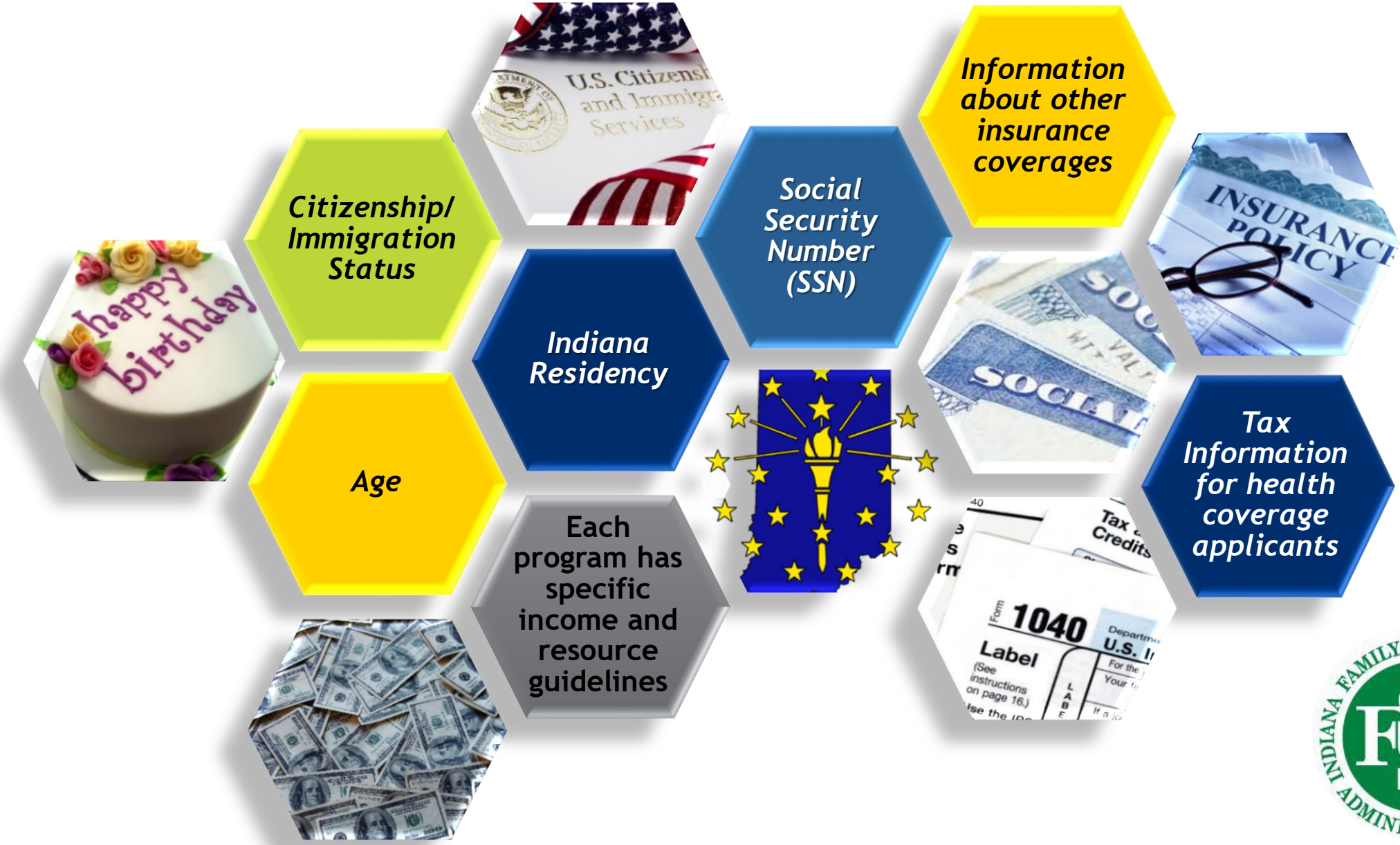
- ✓ Name
- ✓ Address
- ✓ Signature of applicant

Health Coverage applications can be completed via phone 1-800-403-0864

Redeterminations/Auto Renewals

- A Health Coverage redetermination is a required annual review of Medicaid assistance groups to determine continuing eligibility
- Timeframes for the review varies dependent upon when eligibility initially began
- Some eligibility redeterminations are automatically determined by specific systematic criteria and others require the return of a mailer which must be signed by the client or the authorized representative
- If changes are reported verification must be returned with the signed mailer

General Eligibility Factors and Requirements



Medicaid Hierarchy

MASI – SSI Recipient

MA 2 – Age 6-18, 106% FPL

MA 9 – Under age 18, 158% FPL

MA10 – Under age 18, 250% FPL, premiums apply

Indiana Health Coverage

Health Coverage Program Overview

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Health Coverage Rights and Responsibilities

“Your rights to payments for medical care are assigned to the State of Indiana if you are found eligible for benefits. This includes rights to medical support and payment for medical care that you have on behalf of yourself and your dependents who are approved for benefits under this application. However, the assignment does not include Medicare payments.

You must tell us about health insurance that you have. You must tell us about any legal or administrative actions you take to get payment for medical care, such as a personal injury settlement.

The establishment of paternity is an important service for Medicaid/Hoosier Healthwise members that benefits children who do not have legal fathers. We encourage you to contact your local child support office in your County Persecutor's office when children are enrolled in Medicaid/Hoosier Healthwise. Except for Children enrolled in Package C, there is no cost for this service or other child support service.”

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Health Coverage Overview

Indiana offers Medicaid coverage to those who meet specific non-financial, income and resource requirements in several different medical categories of assistance

Eligibility determinants include, but are not limited to, the age of the applicant, family income, resources and other requirements

Dependent upon the category the applicant may be eligible for, they must select a Managed Care Entity(MCE) that will coordinate care

Coverage may include medical care such as doctor visits, prescription medicine, mental health care, dental care, hospitalizations, surgeries and family planning at little or no cost to the member or the member's family

MCE's Options

- **Anthem**
- **CareSource**
- **Managed Health Services (MHS)**
- **MDWise**

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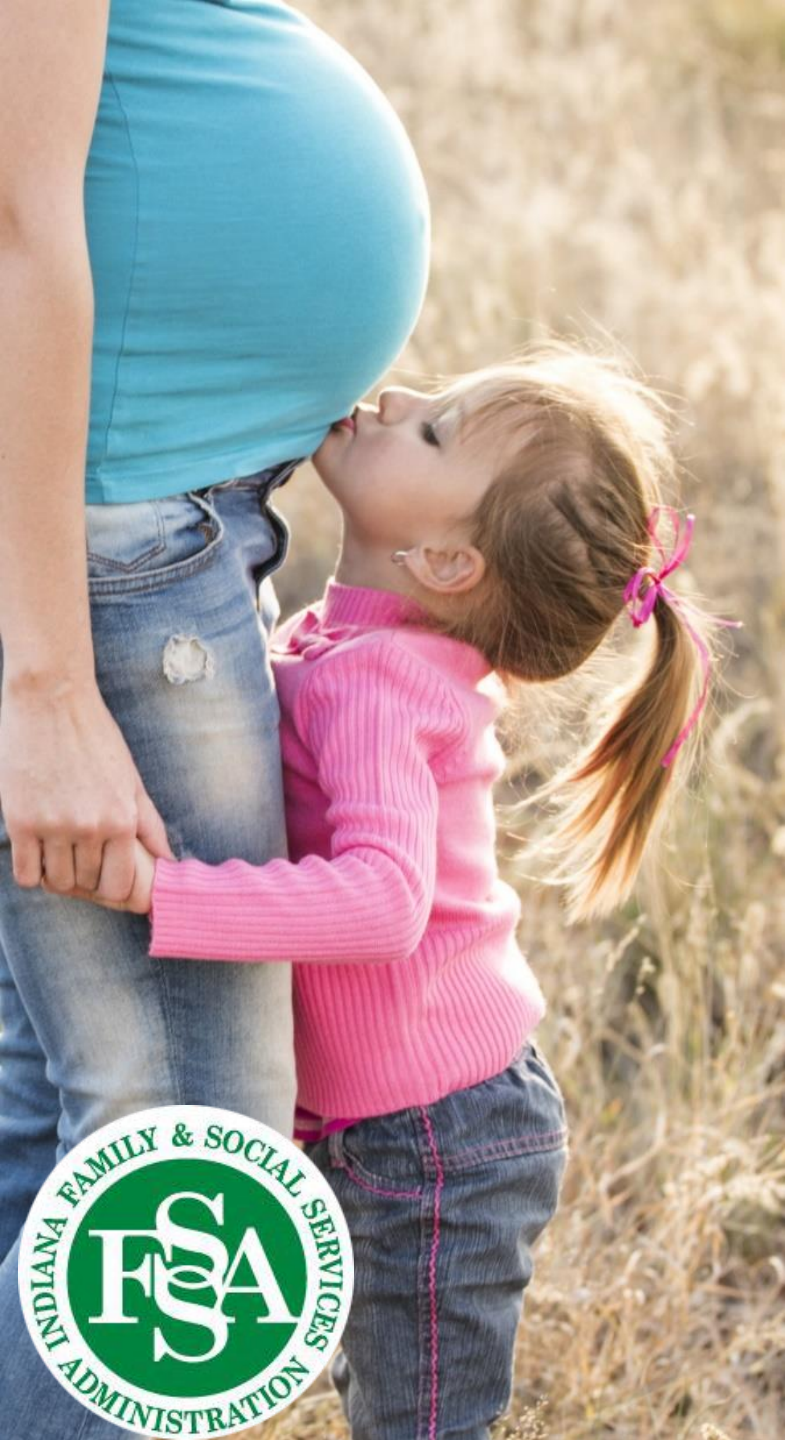


Hoosier HealthWise (HHW)

Indiana's health coverage program for children and pregnant women with low income

Based on family income, children up to age 19 may be eligible for coverage

HHW covers medical care such as doctor visits, prescription medicine, mental healthcare, dental care, hospitalizations, surgeries and family planning at little or no cost to the member or the member's family

HIP Overview

- Covers uninsured adults age 19-64 and not eligible for other medical coverage
- Individual may contribute to a Personal Wellness and Responsibility (POWER) Account
- Applicant must select a Managed Care Entity (MCE)
- Special rules for treatment of unique populations

HIP Waiver Changes

Expanded incentives program

- Tobacco Cessation Initiative/Tobacco Surcharge of 50% after second year of coverage
- Substance use disorder treatment
- Chronic disease management
- Employment related incentives

For more information, visit https://www.in.gov/fssa/hip/2586.htm

New HIP Plus incentive: chiropractor benefits

HIP Member will have the opportunity to switch to another health coverage plan at the end of every year

Pregnant members enrolled in HIP will remain in HIP while pregnant

Contributions are determined by tiers based on income

- Minimum contribution is $1 per month
- Maximum contribution is $20 per month

HIP Plan Options

HIP Plus

- Initial plan selection for all members
- **Benefits**: Comprehensive, including vision, dental and chiropractic
- **Cost sharing**:
  - Must pay affordable monthly POWER account contribution- determined by tiers based on income
  - No copayment for services (Exception: using the emergency room for routine medical care

Best Value

HIP Basic

- Fall-back option for members with household income less than or equal to100% FPL only
- **Benefits**: Meets minimum coverage standards, **no vision, dental or chiropractic coverage**
- **Cost sharing:**
  - Members are not required to pay a monthly POWER account contribution
  - Must pay copayment for doctor visits, hospital stays, and prescriptions

More information on Plan Comparison can be found at:
http://www.in.gov/fssa/hip/files/IN%20HIP-PlanChartSmmry_48rc_012517.pdf

Modified Adjust Gross Income (MAGI)

MAGI includes taxable income for the year in which eligibility is determined for all members of the household

The "household" is determined based on tax relationships

MAGI uses most of the same rules used by the Internal Revenue Code to determine adjusted gross income (AGI)

AGI is then modified by adding foreign income, tax exempt interest, and Social Security (SSI is exempt)

Additional information can be found in the Indiana Heath Coverage policy manual

Unique Populations

Medically Frail	Individuals (Ryan White) with a disability determination, certain conditions impacting their physical or mental health or their ability to perform activities of daily living such as dressing or bathing will receive enhanced benefits • HIP Basic or HIP Plus cost sharing will apply but access to vision, dental, chiropractic care and non-emergency transportation benefits is ensured regardless of cost sharing option • Will not be locked out due to non payment of POWER account contribution
Native Americans	By federal rule, Native Americans are exempt from cost sharing. Can receive HIP benefits without required contributions or emergency room copayments. May opt out of HIP in favor of fee-for-service benefits as of April 1, 2015

HIP Plus Contributions ≠ Premiums

- Unlike premiums, members own their contributions
- If members leave the program early with an unused balance, the portion of the unused balance they are entitled to is returned to them
  - Members reporting a change in eligibility and leaving the program (e.g. move out of state) will retain 100% of their unused portion
  - Members leaving for non-payment of the POWER account will retain 75% of their unused portion
- If members leave the program early but incurred expenses, they may receive a bill from their health plan for their remaining portion of the health expenses
- Members remaining in the program may be eligible to receive a rollover of remaining contributions
  - Rollover is applied to the required contribution for the following year

Medicaid for the Aged, Blind, and Disabled

All categories must meet all other eligibility criteria in addition to meeting income and resource guidelines

MA A

- Covers aged individuals 65 or older

MA B

- Covers blind individuals according to the SSA definition

MA D

- Covers disabled individuals based on criteria defined by the State and SSA

MADW

- Covers disabled individuals who are able to work

MADI

- Covers individuals that have medically improved and are no longer eligible for MA D

MASI

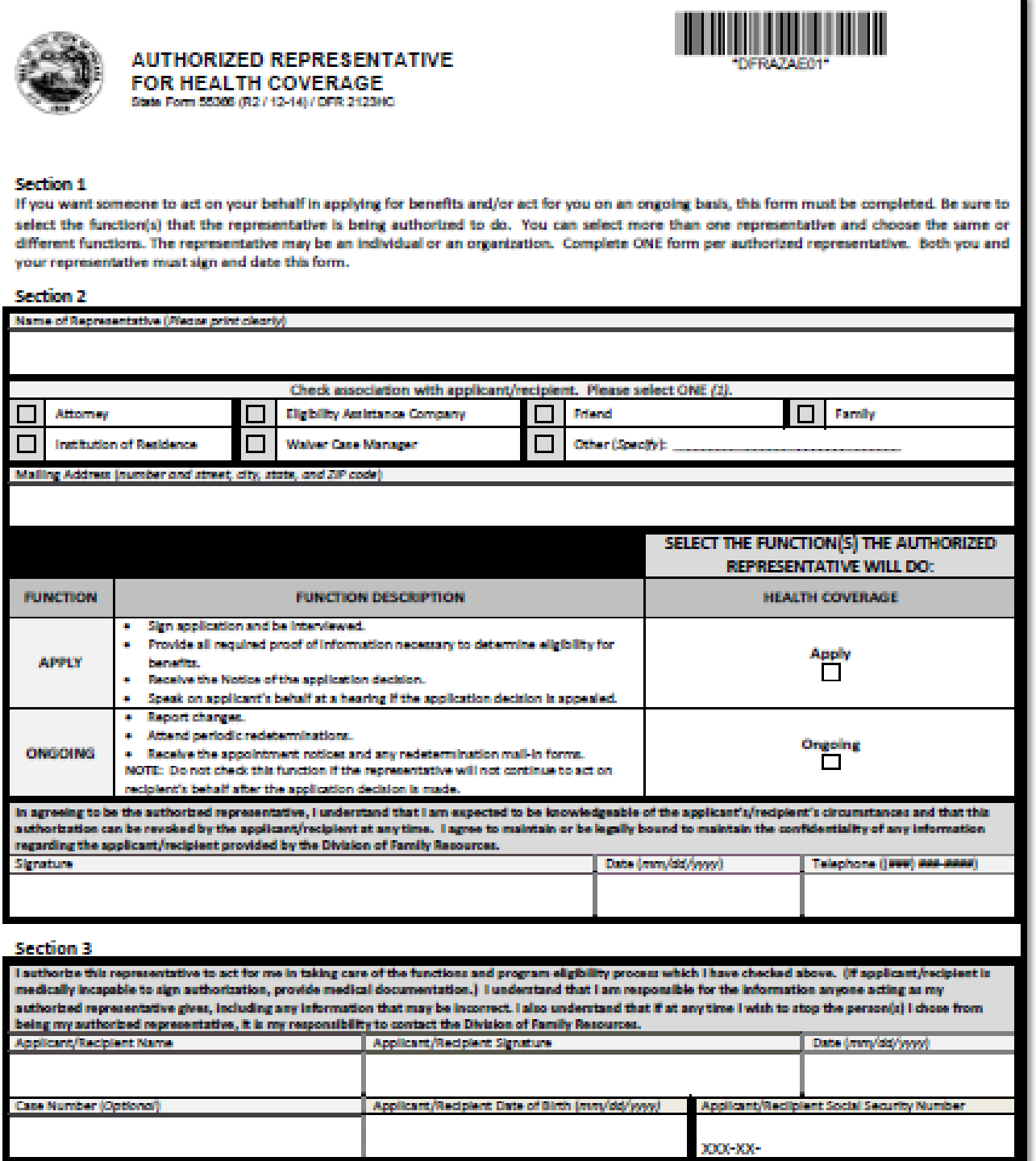
- Covers SSI recipients

Protecting Health Information

Authorized Representatives (AR)

- An applicant or recipient can appoint or designate an individual or organization to serve as an authorized representative on their behalf

- An individual or organization may assist with the application, renewal, or recertification of benefits as well as receive copies of notices



AUTHORIZED REPRESENTATIVE
FOR HEALTH COVERAGE
State Form 55366 (R2 / 12-14) / DFR 2123HC

"DFRAZAE01"

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (Please print clearly)

Check association with applicant/recipient. Please select ONE (1).

☐ Attorney	☐ Eligibility Assistance Company	☐ Friend	☐ Family
☐ Institution of Residence	☐ Waiver Case Manager	☐ Other (Specify): _____	

Mailing Address (number and street, city, state, and ZIP code)

FUNCTION	FUNCTION DESCRIPTION	SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO: HEALTH COVERAGE
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	Apply ☐
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. NOTE: Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	Ongoing ☐

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.

Signature	Date (mm/dd/yyyy)	Telephone ((###) ###-####)

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (mm/dd/yyyy)

Case Number (Optional)	Applicant/Recipient Date of Birth (mm/dd/yyyy)	Applicant/Recipient Social Security Number
		XXX-XX-

AR Form

- If printed from the application Benefits Portal the health coverage form contains a bar code and is unique to a specific case. Copies of the form should not be made to attach to other cases, and the bar code should not be altered under any circumstances
- Generic Authorized Representative Forms can be found at the link at http://www.in.gov/fssa/dfr/2689.htm
- Both the AR and the individual must sign the form.

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AR Form (continued)

- During form completion the AR and the applicant will determine their specific functions

  - **Apply functions include:**
    - Sign the application on behalf of the applicant and represent the applicant during an interview
    - Provide all required verifications to determine eligibility
    - Speak on behalf of the applicant at appeal

  - **Ongoing Functions include:**
    - Reporting Changes
    - Attending redetermination/renewal interview if applicable, or completing redetermination/renewal mailer
    - Receiving notices

Authorization for Disclosure of Personal Health Information Form

This document is utilized to authorize an individual or agency to obtain information for a specific amount of time which generally expires in 60 calendar days. Receipt of this form **does not** translate into the same information that an AR would receive.

DFR Contact Information

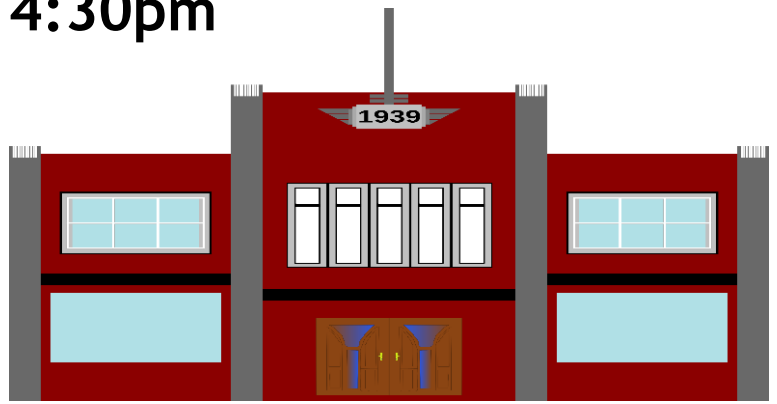
Reporting Information

Statewide DFR Telephone/FAX:

1-800-403-0864

FSSA Document Center
P.O. Box 1630
Marion, IN 46952

State Local Offices Mon-Fri 8am to 4:30pm

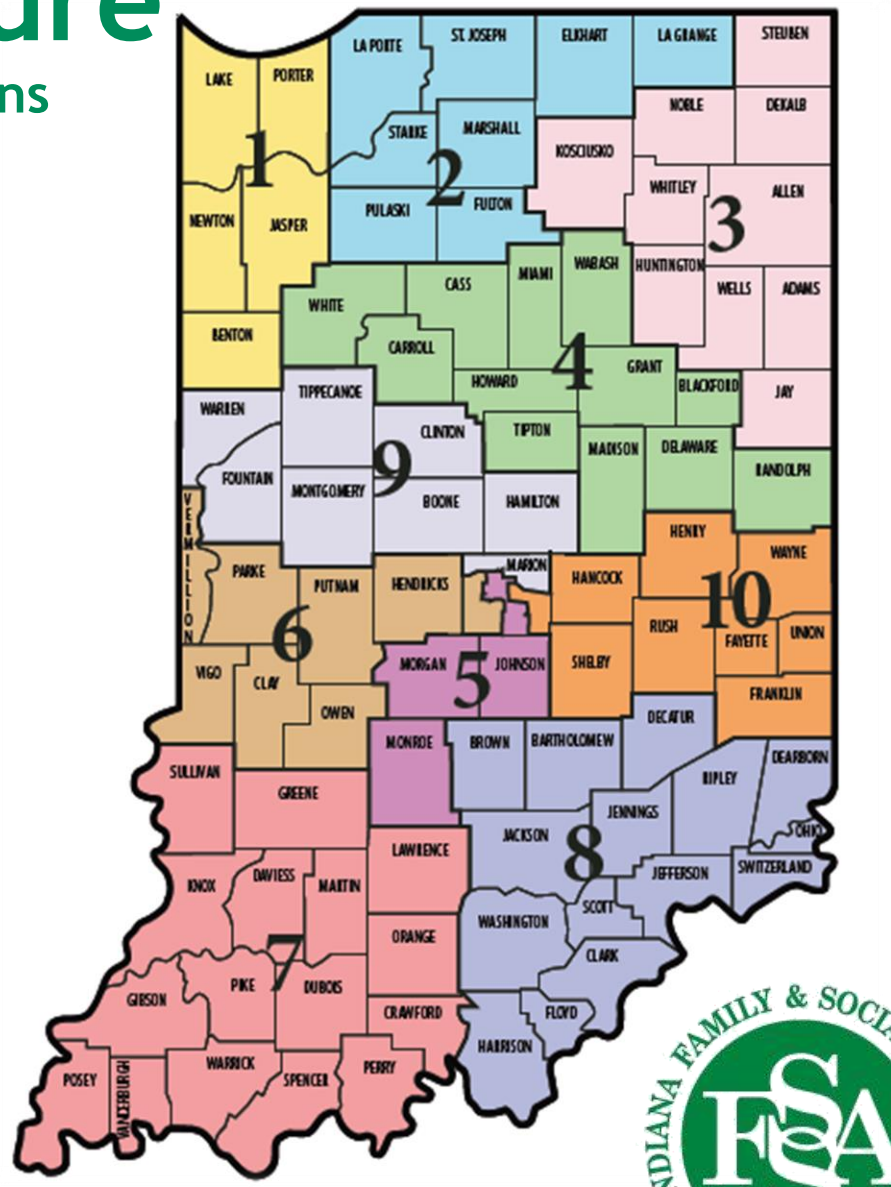


Statewide Eligibility Structure

Regional Manager and Deputy Regional Manager in 10 Regions

Each region has a mailbox where inquiries can be sent for general questions. A response will be received within 3-5 business days. Note: for case specific questions, the inquiring individual must be designated as an authorized representative or have Power of Attorney.

Region 1: Lake (DFR.Region1@fssa.in.gov)
Region 2: St. Joseph (DFR.Region2@fssa.in.gov)
Region 3: Allen (DFR.Region3@fssa.in.gov)
Region 4: Grant (DFR.Region4@fssa.in.gov)
Region 5: Marion (DFR.Region5@fssa.in.gov)
Region 6: Vigo (DFR.Region6@fssa.in.gov)
Region 7: Vanderburgh (DFR.Region7@fssa.in.gov)
Region 8: Clark (DFR.Region8@fssa.in.gov)
Region 9: Tippecanoe (DFR.Region9@fssa.in.gov)
Region 10: Wayne (DFR.Region10@fssa.in.gov)



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Online Policy Manuals

Division of Family Resources

SNAP & TANF

https://www.in.gov/fssa/dfr/3301.htm

Health Coverage

https://www.in.gov/fssa/ompp/4904.htm

FAQs

Question	Scenario	Where to Refer Question
Why has HIP coverage not started yet?	If you think you have made a payment but have not yet received confirmation of the start of your HIP Plus coverage, please contact your health plan to make sure they received your payment.	**Health Plan**
Why has HIP coverage been denied or terminated?	If your HIP 2.0 coverage was denied or terminated due to non-payment **but you think you paid**, please contact your health plan/MCE.	**Health Plan**
	If your HIP 2.0 coverage was denied or terminated for any other reason please contact the DFR.	**DFR**
Your question or concern is not on the list, or you can't get your concern resolved	Please submit an inquiry directly to the Indiana Family and Social Services Administration (FSSA) by completing the form at https://www.in.gov/fssa/2404.htm#hip. You may also find this form online at www.in.gov/fssa by clicking on "contact us" on the bottom left of the screen. When submitting an inquiry please provider you member ID number (RID number) if you have one and describe your question or issue in detail. After submitting your inquiry you will hear back from someone at the state about the status of your issue within five business days.	


QUESTIONS
ANSWERS
INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
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Session Survey

Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1072